New Jersey Department of Health and Senior Services
Office of Home and Community Services
Adult Day Services Program for Persons with Alzheimer's Disease or Related Disorders
PO Box 807
Trenton, NJ 08625-0807

CLIENT FUNDING UTILIZATION

	Name of Agency
Name of Client	Social Security Number
Street Address	
City, State, Zip Code	

A. Total Adjusted Income of Client (or Client and Spouse) $ _____

B. Per Diem Reimbursement by NJDHSS Alzheimer's Adult Day Services $ _____

C. Co-Payment to be Assessed per Unit of Service $ _____

D. Alzheimer's Adult Day Services Funding Start or Renewal Date _____

E. Weekly Units (Days) to be Provided Through:

- Alzheimer's Adult Day Services _____
- Statewide Respite _____
- Medicaid _____
- CCPED _____
- SSBG _____
- Older Americans Act _____
- Peer Grouping _____
- JACC _____
- CAP _____
- Other Funding Source (Specify): _____
- Pay Privately _____
- Total Weekly Units _____

I have agreed to the co-payment rate listed above.	
Signature of Primary Caregiver	Date
I have reviewed the payment plan with the client's caregiver.	
Name of Agency Representative	Title
Signature	Date